ORIGINAL

COMMONWEALTH OF KENTUCKY
DEPARTMENT FOR MEDICAID SERVICES

TRANSCRIPT

OF

DRUG MANAGEMENT REVIEW ADVISORY BOARD MEETING

August 29, 2001
1:30 P.M.
Room 125, Capitol Annex
Frankfort, Kentucky 40601

MEMBERS PRESENT

Robert Hughes, M.D.
CHAIRMAN

Phillip Baier, O.D.
George Rodgers, M.D.
Richard W. Arnold, M.D.
Patricia Freeman, R.Ph. Ph.D.
Melody Ryan, Pharm. D.
Janet Poe Wright, Pharm. D.
Danna E. Droz
(Proxy for James Davis, M.D.)

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later to get the second one filled.

CHAIRMAN HUGHES:

We actually addressed that issue. There were some three-day prescriptions written and then shortly behind that something else followed. Any other questions from the Board on that? Okay.

The Purdue Pharmaceutical Company had requested five to ten minutes to discuss, I believe, pain management and the Oxycontin issue.

MR. CONNALE:

On behalf of Dr. Hughes and the DMRAB Committee, I would like to thank you for the five to ten minutes that we will be addressing a couple of ideas this afternoon.

I'm Kevin Connale. I'm the Account Executive in the Managed Care Division out of Cornelius, North Carolina. And to my right is Dr. Ruth Plant, our Medical Liaison, who she and I both cover Kentucky covering the Medical Board, Pharmacy Board, Pharmacy Association, Medical Association, and Medicaid.

In the next few minutes, I'd like to introduce to you some things that we are currently doing in the State of Kentucky and have been doing and also some examples that we have actually done and worked with the State of Mississippi with their Medicaid Drug

Utilization Review Committee to mail to physicians within the State of Mississippi.

Before I get started, I wanted to let you know some of the materials that are currently going out in the community are not part of your packet. If you would like any of these additional copies, I could get those to you. But I wanted to let you know what I thought would be most appropriate for physicians within your network within the State of Kentucky.

One of the very popular components right now is an opioid therapy documentation kit that's on a CD rom. This is something that can actually be ordered in through a VCR card that we could actually put into a packet such as the one in front of you.

The Pharmacy Board and Pharmacy Association have just, as of this morning, have supported the anti-diversion brochure that will be going out to every pharmacist in the State of Kentucky. And the Kentucky Board of Pharmacy has also sent out two CE's. These are CE's that are two hours for physicians, pharmacists, nurses, and case managers. The first that went out this past spring was called the Use of Opioids in Chronic Non-Cancer Pain. The one that will be going out in the next month is called The Impact of Chronic Pain and Interdisciplinary Perspective.

Inside your folders, though, I've included some pieces that have not gone out to give these value added. And the reason that I'm here today is we know that education is the key when it comes to health care professionals dealing with a disease state such as pain management. And, so, I chose two of the pieces that Mississippi Medicaid decided to mail, but I also included five other pieces that have been extremely popular for the various organizations that Dr. Plant and I have called on.

The first is a zero to ten pain scale. This is exactly what is being used more and more because of the Joint Commission standards for pain as a fifth vital sign. And, so, this is one of the first steps of treating pain within one's office, long-term-care facility, hospital, etcetera.

One of the other materials that actually went out through the Medical Association for the State of Alabama, MASA, was How to Stop Drug Diversion and Protect Your Practice. This would be a nice reference to use for physicians within his or her own practice on how to treat pain for the legitimate patient but keep an eye out for those who may not be legitimate.

The third piece is one that is a managed care piece which is my department and that's called

Principles of Highly Effective Pain Managers, and it really discusses the impact of pain as a fifth vital sign and how to appropriately treat pain on a daily basis.

One of the other materials is a joint statement that came out back in 1997 from the American Academy of Pain Medicine and the American Pain Society of the use of opioids for chronic non-cancer pain, and this basically is a statement referenced by these two influential organizations.

One of the other pieces that just recently came out is a joint statement from the American Pain Society, the American Academy of Pain Medicine, and the American Society of Addiction Medicine, and these are common definitions used in the treatment of pain -- addiction versus pseudo-addiction, tolerance versus pseudo-tolerance. So, these are one of the joint statements that just recently came out to accompany the other brochure I just referenced.

One of the interim directors for the American Academy of Pain Management is Dr. Barry Cole who put together Clinical Practice: Ten Tips to Survive Opioid Prescribing, and this is something that is really short and sweet. It's really helpful for physicians when he or she might be prescribing an opioid.

Also in your packet is a CE that has not gone out to any physicians, pharmacists nurses, or case managers in the State of Kentucky, and that is one called The Cost of Pain. This is one that each one of you can order to review for your own as well as benefit from the CE's, and Dr. Barry Cole was the writer of this particular CE. And this would give a value-added service to physicians within the State of Kentucky that would not have received this CE so far.

And, lastly, part of the opioid therapy documentation kit, this, along with the Ten Tips to Opioid Prescribing, these were the two pieces that the State of Mississippi approved through the DUR Committee to mail out to physicians within the State of Mississippi. And the Purdue logo is not on the Ten Tips to Prescribing but is on the Pain Agreement.

The Pain Agreement is probably one of the most beneficial tools that health care professionals can receive, and that is basically having a patient agree to one physician and one pharmacy and having the patient choose the pharmacy he or she would like to use.

But by mailing these out, the Purdue logo can be removed, and that was an issue with the State of Mississippi. This logo was taken off and these two

pieces were mailed out with a letter from the State of Mississippi Medicaid.

So, I wanted you to have these folders to review, and all of these materials can be mailed out at one time. You could choose just one. You can choose two. But I wanted to let you know of the third-party materials that are available to help treat a painful, legitimate patient and this is something I wanted you to have a chance to have.

DR. PLANT:

In addition to these efforts, we've been working with the Medical Board as well and we're assisting them in mailing out the new Kentucky Medical Board guidelines for the appropriate use of opioids in treating intractable pain. And those should be going out within the next couple of weeks to all the physicians within the state.

So, we felt that this educational effort might be a nice complement to follow up the guidelines to help educate physicians. We know physicians and pharmacists traditionally, to this date anyway, don't get a lot of pain management education in school. And if we can help supply third-party, nonprofessional pieces that might help with that educational process, that's why we're coming to you all to see if you'd like

to work with us with a mailing.

CHAIRMAN HUGHES:

Let me just make one comment. Pain management is a part of every training because you take care of people with terminal cancer and there's an appropriate way to do that. So, on that one point, I would disagree. There is appropriate training that's been received.

But there are some things in here that appear to be worthy. This Pain Management Agreement looks to be pretty good because you've got the person's signature there to agree to abide by those rules. And if you abide by those rules, the chance of the person abusing the system, so to speak, is much less. So, that's a good piece.

But, again, I would just disagree on the fact that pharmacists and physicians have not had training in pain management. They treat thousands of people with pain.

DR. PLANT:

I'm basing that on some of the studies where physicians have been surveyed. Fifty-three percent of oncologists surveyed considered their training to be poor. I'm basing it on surveys such as that. So, maybe there was training but maybe they felt it was inadequate to meet

some of their needs.

CHAIRMAN HUGHES:

But I don't know how you could improve upon that other than the physician seeing that the patient is in pain or the patient expresses pain and, therefore, they relieve the pain and they follow that up with a question, are you relieved. I mean, how better can you improve upon that?

DR. PLANT:

That's true. The nice thing about the CD documentation kit, and as Kevin pointed out, we could put in a little card if physicians would like this, we can send it to them, is that that opioid agreement is on here, but there's also assessment tools on here, initial and ongoing assessment tools, and these are just templates. So, if a physician, for instance, had the agreement, Dr. Hughes, and said, gee, I'd like to add something to that, they could do that. This just simply acts as a template.

So, if you're interested in using the agreement, you might want to consider also a VCR card that would allow them to order this as it gives more tools and it's a template, so, if they want to adjust it to their practice setting, that would enable them to do that. And we can leave this copy with you all and

you're more than welcome to play with it and look at it.

CHAIRMAN HUGHES:

Thank you. Any questions from the Board? Dr. Rodgers.

DR. RODGERS:

I do have a couple of comments actually. This one I think I tend to disagree with Dr. Hughes a little bit. My question is that the major routes by which this stuff is being diverted are not going to be affected by that sort of an agreement because it's not the little old lady who is getting this inappropriately for arthritis pain.

I think the diversion is coming from other sources. Reading the local newspaper in this area leads me to believe that both you all and other states are looking at other mechanisms by which the distribution and prevention and diversion need to be undertaken.

I'm a pessimist when it comes to physician education even though I'm a physician. I don't argue that we shouldn't try it, but I'm not very optimistic that it's going to make big changes. And particularly I'm not very optimistic that it's going to make big changes in the area of narcotic diversion because the people who are doing that know what they're doing.

They're not doing it because they're uneducated, by and large.

And I'm curious if you would share with us some of the other alternative approaches that perhaps Kentucky ought to be thinking about along with other states that are facing this same problem.

DR. PLANT:

By other approaches, could you be more specific?

DR. RODGERS:

Control on distribution, other controls on distribution. Some of your northeastern states are looking at legislative ways of doing that. My understanding was that Purdue as a corporation was cooperating in some of those attempts. Would you care to discuss those?

DR. PLANT:

Well, we're actually involved, as you've probably read, in the State of Virginia with them in developing a pilot. You all have been very fortunate to have the KASPER system here. Very few states to this point have had any form of a monitoring system. And, so, we're trying to help develop what would be the ideal monitoring system, a tool that maybe physicians could use at the point of seeing the patient as opposed to something more retrospective. So, that's one area

we're working.

Obviously, diversion can happen and abuse and misuse can happen from a multitude of angles. In Kentucky, you all have your tamper-resistant prescriptions, but in other states they have not. So, we've worked with that.

You mentioned that you didn't feel opioid agreements were necessarily 100% effective and they're not. But what I found with speaking with physicians is they don't want to be confrontational with their patients. They want to believe their patients and we're told we should believe our patients with regards to pain. But this gives a physician who is trying to do the right thing a mechanism to outline the patient's responsibilities and the physician's responsibilities. And if the patient, in fact, breaks those responsibilities, it gives them a mechanism to cut that patient loose in a very non-confrontational black-and-white way.

So, there are physicians that I do think that this agreement is helpful. So, I don't know if that answers your question.

DR. RODGERS:

I think there are really two issues. There are generic issues with narcotics. I don't necessarily mean to

pick on you guys, but you're sitting there.

DR. PLANT:

That's all right.

DR. RODGERS:

One is appropriate use and I think you've addressed that with some of the materials relative to pain management, and I think that's good. The other is the diversion issue which you guys have taken the short, so to speak, in the last year as a particular drug entity.

In addition to being a practicing physician, I also run the Poison Center in this state, and I can tell you that we don't get Oxycontin overdoses that are accidental in people who are taking the drug appropriately and all of a sudden something happens. The people we get are the people who are getting this drug through either illicit means or abuse or are getting it through illicit means for overdose, intentional overdose, and it is a problem. There are a slew of them, a disproportionate slew of them, and I don't really think we need to talk about that.

But I think that the tools in here are directed primarily at the former, which is appropriate use for people who perhaps need narcotics and both educating the patient and working with the physician for perhaps

better ways of minimizing that or using it appropriately. That's fine.

But I think to get at the other which has been the one that's attracted all the attention in this state for some appropriate reasons, I think we need to think out of this box. We're going to have to think out of this box.

DR. PLANT:

Again, hopefully, things like the ten tips and the anti-diversion brochures will put some concepts into physicians' minds as far as documentation and ongoing monitoring of their patients.

MR. CONNALE:

And one footnote on that. You brought up a good point, Dr. Rodgers, and that is what can be done. I have actually offered and had implemented two educational programs for program integrity for the State of Mississippi and for Tennessee. And both programs were very well received on why are you seeing an increase in opioids. Who is appropriate. Who may not be.

But the one follow-up I have had with Tennessee was the pain agreement, and that's something that some physicians are using. Some are starting to use it more. But that is one way of finding out who is drug-

seeking, who is having drug-seeking behavior.

So, what Dr. Hughes was alluding to is that's a nice, as Ruth also mentioned, is a nice first step because that has sort of helped with that concept of making sure people that are legitimate---

CHAIRMAN HUGHES:

Let me just say one thing. The agreement is not a cure-all, like Dr. Rodgers said. And the agreement, as you picked up on, is a way to hopefully reduce some confrontation and also it establishes an automatic mechanism for cutting that patient off if they're drug-seeking with one violation.

But the other thing, too, and this is just a thought on the KASPER report. If someone comes in and they want something that you have the least index of suspension on, just get a KASPER report, but ask the first question, is there anyone else writing those controlled substances, and frequently you'll get the answer, no. Run the KASPER report and right there you've got your violation of the---

DR. RODGERS:

I think we get it from the point of view of who is prescribing and who is using. The other issue that has hit the press this week, as you're probably aware, not with Purdue Frederick but with one of your

colleagues in the pharmaceutical industry, is the responsibility of the company when they realize that there is a distribution problem. This relates to the issue in Arkansas.

But I think the same thing potentially could relate to suppliers of narcotics. If you know that you're shipping three truckloads of this stuff a month to the pharmacy in Paintsville, I mean, what's the obligation to let us know that this stuff is going in the back door in truckloads and it's going out the front door somehow? I don't know the answer to that.

DR. PLANT:

Obviously, we can't comment on that because---

DR. RODGERS:

The question was raised this week and it's going to be raised in a courtroom and we'll see what the liabilities are.

DR. PLANT:

Well, again, I think any manufacturer is obligated to make sure that they are providing appropriate education for the appropriate use of their products, and that's what we're here to try to do. So, hopefully, we'll strike up some interest from you all and maybe do a cooperative mailing with any of the pieces you find interesting.

CHAIRMAN HUGHES:

Any other questions? Steve.

MR. HILL:

I just wanted to comment on Dr. Rodgers' comment about the distribution. That is in place now. The DEA routinely monitors at the wholesale level where those drugs go, whether it's two, three or four. And anyplace that has outside of the norm gets an audit. I've actually had one on a cough syrup one time because all the physicians started on this one particular hydrocodone cough syrup and they said, well, you're using too much. Well, everybody down here likes it. But that does happen and it is there.

CHAIRMAN HUGHES:

Any further comments? Thank you. Under New Business, the Senate Bill 351 and House Bill 608 drug reviews, I believe Cliff and Dr. Moore were going to present that.

DR. MOORE:

Yes. In accordance with KRS 205-5631 through 34, we are continuing to do the new drug reviews and the comparable drug reviews. We have two that we have received from the UK Special Unit for a presentation to the Committee today.

PROFESSOR HYNNIMAN:

These two reviews both have some issues in

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PAUL E. PATTON
GOVERNOR

ISHMON F. BURKS
COMMISSIONER

September 17, 2001

Governor's Oxycontin/Prescription Drug Abuse Task Force Members:

On Tuesday, September 18, 2001, at 1000 hours, I will be presenting the results and recommendations of the task force to the Judiciary Committee of the Kentucky General Assembly. I would like to extend my personal invitation for you to attend this hearing, located in Room 149 of the Capital Annex.

I have enclosed a copy of the interim OxyContin Task Force Report for your review. You will be notified of a follow-up meeting regarding this report and the results of the presentation to the Judiciary Committee.

If you have any questions, please contact me at 502-695-6300.

Sincerely,

Ishmon F. Burks,
Commissioner

IFB/lmr